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Extra-uterine pregnancy

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EXTRA-UTERINE PREGNANCY.

*Report of Three Cases.**

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Having been requested to prepare a paper on some practical subject to be read before you, I have selected the trite subject of Extra-uterine Pregnancy, as presented in three cases that have come under my observation. They have been of interest to me and I hope may prove so to you. Without occupying any of your valuable time with remarks I will proceed with the report of the cases:

CASE I.—Mrs. B. came to me six years ago giving the following history: She was thirty-five years of age; had been married fourteen years; had one child thirteen years of age. Her menstrual history had been remarkably normal until her present trouble. She had never aborted. She stated that she had had, about one year previous to seeing me, what was diagnosed as an extra-uterine pregnancy. This condition was not recognized until the third month. She was treated first by aspiration *per vaginam*, and a small amount of blood withdrawn. As the tumor continued to increase in size a strong faradic current was used, one pole being placed in the vagina and the other on the abdominal wall over the mass. This resulted in an amelioration of her symptoms, and a decrease in the size of the tumor. This diminution in the size continued up to the time of her consulting me. When I first saw her she complained of great pain and tenderness in the mass, painful micturition and defecation. She was unable to walk or to attend to her household duties without great suffering.

On examination, I found a mass high up in the pelvis, pressing the uterus forward and downward. It extended above the brim of

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the pelvis, and occupied the lower right lumbar, and entire iliac region. This mass was about the size of a cocoanut, and only slightly movable. On pressure there was great tenderness.

Objecting to operation she was treated with large hot douches, boroglycerin tampons, etc., with some relief, although there was no decrease in the size of the mass. This treatment was continued, at intervals, for two years. She then had an attack of severe pain in her right side. This was accompanied by a chill and a temperature of 102.2° F. The mass increased in size and tenderness during the succeeding days. I advised immediate operation, but she refused.

There were irregular exacerbations of fever which culminated, on the eleventh day, with a temperature of 104° F. During that night a foul-smelling diarrhœa set in with a marked decrease in the size of the mass and a relief from pain. Examination of the stools showed them to consist of pus, adipocere, and a few bony fragments. The patient slowly recovered from this attack, and one year later she consented to an operation for the removal of the old sac.

She was admitted to the Woman's and Children's Hospital of Syracuse, October 20, 1892. After the usual preparation of a week I operated, assisted by the hospital staff. Upon opening the abdomen I found a mass about three inches in diameter, dipping down into the pelvis posterior and to the right of the uterus and extending upward toward the right, and firmly adherent to the surrounding structures. The most difficult part of the operation was the separation of the mass from the cæcum. Undoubtedly this was the place where the sac discharged its contents into the intestines one year previous. After the mass was freed from its attachments the pedicle was transfixed and tied with a double silk ligature, and the mass removed. The abdomen was then flushed with sterilized water. As there was considerable oozing from the torn adhesions, I used a glass drainage-tube.

The wound was closed with silk and two stitches including the skin, fascia and peritonæum were passed at the site of the drainage-tube and left untied. The dry iodoform dressing was applied. The drainage-tube was removed in thirty-six hours, and the two stitches were then tied closing the opening left by the removal of the tube. The patient made an uneventful recovery, her highest temperature being 99.2° F.

Examination of specimen showed it to be a sac containing about an ounce of cheesy pus. The walls were formed in part by inflammatory material and in part by the Fallopian tube which opened into

it. The remains of the ovary were imbedded upon the anterior surface of the mass. This case seems to me to be a very good illustration of the remote dangers of the electrical treatment of extra-uterine pregnancy. If the patient had undergone the operation when the condition was first recognized she would have escaped years of suffering—for she was never free from pain until after the sac was removed. She would have escaped the danger of suppuration of the cyst, and its rupture, which, fortunately for her, was in a direction where it did the least damage. In addition, this procrastination allowed numerous attacks of localized peritonitis, with the resulting adhesions, which increased the gravity of the final operation.

I think this case is a strong argument against the electrical treatment when the pregnancy has advanced as far as the third month.

The two following cases are very similar:

Case II.—Mrs. G., aged twenty-nine years; Irish; married five years; has had two children, the elder four years, the younger nine months. Menstruation always regular, except while she was pregnant or nursing. The last child she was able to nurse but two months, as the secretion of milk failed. Menstruation returned one month after weaning. She continued regular for five months. Two weeks after the cessation of her last menstruation she had an attack of severe bearing-down pain together with a profuse discharge of blood from the vagina. This confined her to bed for several days. Upon recovery she resumed her ordinary household duties, although the flowing continued in greater or less quantities, and she had daily attacks of pain of a colicky character. During the month that followed she states that she passed several pieces of skin, one of which looked like a bag. I first saw her about four weeks after her first attack. Her condition at that time was as follows: Much emaciated, very pale, ears waxy, lips colorless, anxious, drawn expression. Temperature, 99° F.; pulse, 110; respiration, 28. She complained of great pain in the lower part of the abdomen; urination very painful and bowels obstinately constipated. The flowing had increased and was dark-colored, with numerous clots, but no bad odor.

On examination, I found a large, and very tender, doughy mass, occupying the entire pelvis and extending upward to within one inch of the umbilicus. The uterus could be made out imbedded in the anterior surface of this mass and pressed forward against the neck of the bladder, the fundus of which (bladder) was raised above the pubis. The cervix was patulous and admitted the finger to the inner os. The breasts were negative. I directed her to be taken to the Woman's

and Children's Hospital, and prepared, as soon as possible, for operation. She was so weak that it was deemed advisable to improve her general condition before operating. Accordingly she was placed in bed and given strong liquid diet with wine and the citrate of iron and quinine. Under this treatment she improved in general health so as to be up and about the ward, although the local conditions remained about the same. On May 21st I operated and found a large mass occupying the pelvis and the lower part of the abdomen, displacing the uterus and bladder forward. The omentum was adherent to the anterior surface of the mass. After this was detached the mass was found to be loosely attached to the surrounding tissues by recent adhesions. I had no difficulty in separating these until I came to a band low down in Douglas' *cul-de-sac.* In breaking this, notwithstanding the greatest care, the cyst was ruptured. Its contents, consisting of foul-smelling blood clots, were carefully removed, avoiding as far as possible the contamination of the abdominal cavity. After emptying the cyst I broke the troublesome adhesion and formed my pedicle of the right Fallopian tube and broad ligament. I used the Tait knot. The left tube and ovary being diseased, I removed them. The abdominal cavity was flushed with sterilized water and a large number of old blood clots that had escaped when the cyst ruptured were washed out. A glass drainage-tube was introduced deep into the pelvic cavity, and the wound was closed with a single row of interrupted sutures, two being left untied where the tube protruded.

The operation lasted about an hour, and when finished the patient was in a profound shock. By the use of hypodermics of nitroglycerin, digitalin, strychnine, etc., she rallied for a short time and then began sinking. The median basilic vein was then opened and one pint of a three fourths of one per cent. saline solution was slowly injected. The pulse immediately improved, the pallor of the skin became less marked, the deathlike expression of the face disappeared and the patient regained consciousness in a short time. The improvement continued and she made an uneventful recovery. The temperature never rising above 100° F.

Examination of the tumor showed it to be a hæmatocele encapsulated by adhesive inflammation. The walls of the cyst consisted of laminated blood clots covered by inflammatory exudate. The right Fallopian tube communicated with the hæmatocele by a rupture on its posterior surface. The right ovary was imbedded in the anterior wall of the mass. No fœtus was found. Unfortunately the specimen was lost before a microscopic examination of the tube could be made.

CASE III.—Mrs. T., aged thirty-five; married nine years; menstruation began at sixteen, twenty-eight-day type, normal in amount and color. She had had three children, the oldest eight, and the youngest three and one half years. Two years ago she had an attack of metrorrhagia that lasted five weeks accompanied with severe pain in the right side. This pain has continued with greater or less severity ever since. Since the metrorrhagia she was regular as to menstruation until September 1, 1894. On that date she had an attack of very severe pain in the right side which completely prostrated her. This was accompanied by a bloody discharge from the vagina. About a week later she passed several pieces of "skin" *per vaginam.* September 20th, her breasts began to enlarge and become tender also morning sickness commenced. On October 11, 1894, I was called in consultation by Dr. Roth, of Syracuse. Two days before she had had a severe attack of pain in the lower part of the abdomen together with an increase in the bloody discharge. I found her in bed suffering great pain.

Examination showed the breasts enlarged and tender. The uterus enlarged, os admitting tip of index finger. Behind the uterus was a mass of doughy feel, filling the entire pelvis and extending upward nearly to the umbilicus. The uterus was displaced forward crowding the bladder against the pubes. The rectum was so encroached upon that its lumen was reduced to a mere slit.

The patient was removed to the Woman's and Children's Hospital and prepared for cœliotomy.

On October 18, 1894, I opened the abdomen and found the following condition: A large mass composed of a blood clot was found occupying the pelvis and lower part of the abdominal cavity. This clot was incased by an inflammatory exudate. In attempting to separate this from the surrounding structures the fibrinous wall incasing it ruptured discharging its contents partly externally and partly into the abdominal cavity. After clearing out the cavity, the right Fallopian tube was found opening into it by a recent rupture on its posterior surface. I removed it together with the ovary.

The left ovary, containing a cyst the size of an orange, was also removed.

The abdomen was then thoroughly flushed with sterilized water, washing out a large number of clots. The wound was closed by a single row of sutures. A glass drainage-tube was used, which was removed at the end of thirty-six hours. The patient did remarkably well until the fifth day, when she had an afternoon temperature of

102° F. This temperature continued fluctuating, from 99° to 103°, for six days, when it became permanently normal. This was undoubtedly due to the absorption of a small accumulation of blood in Douglas' *cul-de-sac.* Examination of the specimen showed it to be almost identical with the last. A large hæmatocele incased by inflammatory exudate with a dilated Fallopian tube opening into it through a recent rupture on its posterior surface. As in the preceding case, no fœtal structures were demonstrated.

The question of diagnosis in these last two cases I submit to your consideration. Some of the symptoms of early pregnancy were present in both cases. There were probably decidual casts in each, although these pieces of skin, as they were called, were not examined by me. In both cases I found ruptured tubes and large hæmatoceles. No fœtal structures however were demonstrated. Am I justified in classing these two cases as hæmatoceles, due to ruptured tubal pregnancies?